such a ligamentous lacuna itself. The same thing may, of course, be said, *mutato nomine*, for tendinous sheaths. The joints in which such actions are most likely to take place are those having large articulating surfaces and small reflected portions, which act as *diverticula*. When such a knuckle of membrane has, as above described, been pushed out, it withdraws itself more and more, until it forms a cup which constantly secretes fluid and receives fluid from the general cavity, till it becomes distended into a globular excrescence or hernia from the synovial membrane. This protrusion is at first very minute, not so large, perhaps, by half, as the head of a pin, and it may remain always of this size, having still a small communication with the synovial sac, and appearing simply as a little addition thereto. Such appendages have been found connected with various joints, the knee, the shoulder, &c., but above all with the carpus. I have also found them at the astragalo-scapoid. They have been described as normal structures; M. Gosselin, of the Hôpital Cochin, at Paris, draws particular attention to them, and gives them the long name of synoviparous crypts, describes them as destined to increase the amount of secreting surface, and as occurring not only in man but in animals also. He went to the abattoirs of Paris, and there examined the carpal and tarsal joints of a good many horses, and found synoviparous cysts in them. Yet, in spite of all this evidence, I do not believe that the normal condition is the existence of these sacs: because the physiological reason given for their presence is inadequate. Let us consider, for instance, the synovial membrane of the carpal joints, which is so extensive that it lubricates not only the joint between the two carpal rows, but the junction between each pair of bones, and the four inner carpo-metacarpal articulations as well. I say, when we consider the size of this membrane, and the extent of its secretory surface, we shall not readily believe that it can be materially assisted by five or six follicles not so big as pins' heads. Then, again, I have examined many carpal joints, and must acknowledge that, if we take our subjects from the dissecting-room or hospital dead-house, we shall in all probability find synoviparous glands. Such persons are usually somewhat beyond middle age, and have led a hard-working life, but if we take our examples from the hands of children, no such structures will be found. The hands of ladies, who have in their lives done nothing severer than worsted work, come seldom under examination, but in one that I had the opportunity of dissecting, I found no synoviparous crypts, although I studied the whole membrane with a glass. Again, there is a class of women whose mode of life and poverty combined often bring them to the hospital, although their hands are free from the signs of labour: in these, synoviparous follicles are absent. Lastly, they are more common on the right hand than on the left. Indeed, we may take the condition of the skin of the hand to represent the probability or improbability of there being any such excrescences; therefore they are, I believe, abnormal, the result of hard work and straining of the joints, and they occur in the place where we should expect such results to appear—namely, chiefly at the carpus, where the whole secreting surface is very large, and where the portions reflected from one bone to another (which act as diverticula) are small. Moreover, when, from certain positions of the joint, the fluid becomes forced into that space, and presses against the synovial membrane, it must take most effect upon that portion of membrane which is least supported by ligament; and this is just at the angle of reflection, where the membrane leaves the bone. It is at that spot, therefore, that we should expect to find most frequently the results of over-exertion, and it is here that we really do most frequently find synoviparous crypts. As for the animals which M. Gosselin examined, it must be remembered that they were omnibus and fiacre horses, who, after a life of severe labour, had been condemned by the knacker, and therefore creatures on whose joints we should expect to find the results of over-work, as M. Legouest has observed.

The little processes, then, which are found projecting from synovial membranes are not physiological, but pathological formations, produced by a pressure from within, as previously described. They are at first almost microscopic, and may be best seen by examining the inner surface of the membrane, on which (causing it to protrude) they create a slight swelling, generally with an orifice in its centre. One of these excrescences, which shall have passed into a mesh of the ligament, may increase considerably until it protrude through it, forming a tumour on its outer surface. The channel of communication with the original sac may still remain open, or it may have closed, leaving only an imperforate cord passing through the ligament and connecting the cyst with the synovial membrane; or, lastly, even this cord may have disappeared, so that all

means of tracing the origin of the cyst be lost, and it appear like a new formation. In a hand which I dissected during the last winter I found on the first phalanx of the ring-finger an oval tumour, not so large as a horse-bean, the long axis of which corresponded to that of the finger. It was of an amber colour, and adherent by a small point to the fibrous sheath. I removed the sheath with, of course, its lining of synovial membrane, and found, on looking at its inner side, a small opening through which a bristle could be passed, whereby it was shown to communicate with the interior of the tumour. I endeavoured to preserve these parts in spirit, but the semi-fluid contents of the cyst were soon dissolved; in endeavouring to pass a bristle through the narrow opening to act as a spring in the tumour and distend its walls, I unfortunately used a little too much force, and broke it away. This hand had belonged to a coachman, and bore many signs of rough work. The palmar fascia was in one part scarred and contracted into a thickened cord, which prevented straightening of the middle finger; and there were three synoviparous follicles at the base of the os magnum. In hands of this sort, cysts as above described are not very rare. I have seen one on the sheath common to the extensor ossis metacarpi and extensor secundi internodii pollicis. This was bilobular and very tense; the peduncle connecting it to the above-named sheath was very thin and imperforate. I have also seen one at the back of the carpal bones, connected by a stalk to the joint between the scaphoid semilunar and os magnum. I have seen one lying unconnected at this spot. In fact, anyone who carefully examines a number of hands will be sure to find such tumours in different stages of progress, from the first simple bulging of the synovial membrane, to the cyst lying free amongst the tendons and upon the ligaments, which increases like other cysts by virtue of its own secretion, whilst its walls become thickened by a fibrous layer, either derived from the structures through which the tumour has passed, or acquired by the constant friction to which its prominence exposes it, until the cyst becomes hard, round, and elastic, rather than fluctuating.

Having now traced the origin of such tumours from the beginning, we may impose thereon a definite name, and will return to the old word "ganglion," only we will limit its application strictly to this form of malady,—namely, to synovial cysts produced by nipping out, as it were, a piece of synovial membrane from joint or sheath while the rest of that membrane remains normal; and we will not allow it to be misapplied (as is often done) to dropsies of synovial sheath, whose course and history we will next follow.

(To be concluded.)

COMPLETE EVOLUTION OF A CHILD IN UTERO.

By JAMES JONES, M.D. Lond.

I AM desirous of laying before the readers of THE LANCET a singular case of spontaneous evolution of a fœtus during labour, which occurred in my practice a few weeks ago. The form of evolution described by Dr. Douglass, of Dublin, in which the feet and breech came down after the arm and shoulder had passed the brim of the pelvis, has many times come under observation, but a complete evolution of the child, such as I am about to describe, I have not before met with, nor have I been able to find any similar case on record.

Mrs. J. B—, a lady from Tasmania, was taken in labour, at the expiration of her third pregnancy, on the 17th of July last. After fifteen hours of pain, she was delivered of a male child, and about ten minutes afterwards the membranes of a second fœtus began to come down. On their being ruptured, both feet descended low in the vagina, when, as is my usual practice, I grasped both legs high above the ankles, and waited the return of an expulsive pain, which soon coming on, I began to make some traction. To my great surprise, I found the legs forcibly drawn from my grasp, until they quite passed above the pelvic brim, and their place then became occupied by the head, which soon descended, (face to sacrum,) and the labour was rapidly completed. The child appeared still, but artificial respiration being maintained for ten minutes, he cried lustily.

As the shoulders passed the external outlet, I found the right leg forcibly bent on the body, the foot resting on the right

shoulder, or rather in the space between the arm and chest. The other leg was born in the natural position.

It appears to me that in this case we have had an instance of an unusual kind of evolution, for, from the position of the feet low down in the vagina, the child's head, and also the breech, must have each glided over a third of the circumference of the uterus, the breech ascending as the head descended. That the head did not lie just above the brim of the pelvis I am quite certain, for the breech was plainly to be felt on passing the fingers along the limbs, occupying the whole pelvic inlet. It would therefore be impossible for the head to have occupied any position other than either erect or bent on the chest. The latter I conceive to have most probably been its position, as it was most favourable to version. The curve formed by the head thus bent, and the spine inclined forward, would make a segment of a circle corresponding to the curve of the uterine cavity. If the uterus then, acting irregularly, (a thing not at all improbable in a twin labour,) pressed more upon the occiput than on any other part of the child, evolution is not by any means an inconceivable process, the more especially when we consider the half empty state of the uterine cavity after the first child had been expelled.

The placenta was expelled soon after the second child. It was of the double bulk usual in twin cases.

The patient made a most excellent recovery, having suffered but little after-pain.

Woburn-place, Russell-square, 1858.

ON A CASE

OF

HYSTERICALLY-CONTRACTED KNEE-JOINT.

By PAUL HENRY STOKOE, Esq., M.R.C.S., Maidstone.

SARAH A—, aged twenty-one, a servant, came under my care a month ago, with her right leg flexed upon the thigh at an acute angle, and apparently immovable. In the early part of last January, after prolonged exposure to cold, she was suddenly attacked with swelling in her right knee, accompanied by slight heat and redness, but most severe pain. She was leeches, blistered, and otherwise treated antiphlogistically for three months, with little benefit, the swelling only partially subsiding, and the pain remaining unmitigated. For a time the application of warm poultices, the infraction of oil, and the internal administration of opium severally afforded, or seemed to afford, intervals of relief from the agonizing pain, which had assumed an intermittent character. In the meantime the leg became more and more flexed, until the muscles of the calf were in apposition with those on the back of the thigh. After five months of agony she was permanently and *spontaneously* relieved from her pain, a few days previously to being delivered of a full-grown, healthy child, the contracted joint alone memorializing her sufferings.

On presenting herself before me, nearly eight months after the commencement of her illness, I found her to be a ruddy-cheeked, fair-complexioned, red-haired girl, with a prominent eye, large and dilated iris, long eyelashes, fair and white skin, but coarse at the flexures of the joints, with well-formed head, and very intelligent expression; of a highly nervous and susceptible temperament, and possessing low physical, but high moral courage. Her appetite was good; tongue clean; pulse small and soft; bowels rather costive; urine straw-coloured, normal in quantity, but containing a minimum of salts, &c.; the catamenia had not reappeared since her confinement.

On examining the limb, the acuteness of the angle of flexion was so striking as to suggest the improbability of its resulting from the simple overbalance of the flexor muscles of the leg, as seen in diseased knee-joint. This, combined with the girl's history, led me to conclude, that whatever alteration of structure might then exist, originally the disease was not in the joint, but was, in all probability, hysterical. Hence, I was induced to hope the deformity was remediable.

Finding that even the most gentle attempts to straighten the limb were productive of extreme torture, after attending to her general health for a week or two, I put her under the influence of chloroform, and with very gentle force succeeded in restoring the leg to its natural position. As it became gradually straightened, the yielding of contracted tendons and stiff ligaments was

audible, but no actual violence was required to reinstate it. Her manner of receiving the chloroform was highly characteristic of the hysterical temperament. The leg was maintained in position by a light spint, and cold applications applied to the joint for a few days, not to subdue inflammation, for there was none, but rather to assure the patient that she was not neglected. At the same time the pain she complained of was relieved by opiates.

She has not regained the full use of her leg, although possessing considerable power over it at the knee. I have ordered her crutches, so as to enable her to get out into the open air, and to tempt her to resume, gradually, the employment of the long-disused limb. She is also taking ferrous preparations. The entire restoration of my patient I hope to be enabled to communicate at no very distant period.

September, 1858.

EXCISION OF A POLYPOID TUMOUR OF THE UTERUS, WITH THE ATTACHED PORTION OF THE CERVIX UTERI.

By STEPHEN NESFIELD, Esq., M.R.C.S.,
SURGEON TO ST. MARY'S HOSPITAL, MANCHESTER.

CATHERINE N—, admitted into St. Mary's Hospital on the 5th of July, 1858, aged thirty-nine, married; has had thirteen children and three miscarriages. She enjoyed good health up to her last confinement, three years ago, when she commenced suffering from a profuse leucorrhœal discharge, which was frequently tinged with blood. Twelve months ago she miscarried, and since then she has had repeated attacks of flooding, attended with severe bearing-down pains; and within the last two or three months the floodings have been both more severe and recurred more frequently, so much so as not to leave her more than two or three days free from the discharge. During the last week she has been wholly confined to her bed.

Present state.—Extremely blanched, with a hot, dry skin; pulse 120, very irregular. Examining per vaginam, a tumour, globular-shaped, about the size of an egg, is discovered, growing from the posterior and inner surface of the uterus. Between the tumour and anterior lip the finger can be passed a short distance within the uterus, yet not sufficiently high to reach the upper limits of the tumour. It has no neck, and there is no pain on handling it. Seen through the speculum, the surface is pale, but traversed by bloodvessels. Astringents and plugging were resorted to as temporary expedients; wine, brandy, and good diet ordered.

On the evening of the 8th, in consultation with Dr. Steevens, I scooped away as much of the tumour as possible, with the attached portion of the cervix, by means of a blunt, curved bistoury, having the blade bent, so as to form a second curve. The hæmorrhage attending the operation was only slight. The vagina was plugged, and forty minims of Battley's sedative solution were given, to be repeated as often as requisite.

July 9th.—Passed a good night; no hæmorrhage. To have six ounces of wine and three ounces of brandy daily, with beef-tea, &c.

22nd.—There has been no hæmorrhage, no peritonitis, nor signs of any local inflammation; yet her recovery is very slow, and she faints on being moved. At her own request, she was allowed to be taken home.

30th.—Improved in appearance; feet œdematous. Is taking quinine and iron.

August 12th.—Able to sit up for a few hours each day.

Sept. 16th.—Walked to the hospital, a distance of a mile; feels herself strong; is able to attend to her household duties; has had no return of hæmorrhage. The anterior lip of the uterus is considerably hypertrophied.

In this case there was no other plan of treatment that could be adopted with any hope of success. The ligature was out of the question, as it necessarily must either have included the cervix or removed but a very small portion of the tumour; and excising the tumour, as it could not be removed entire, seemed only of doubtful propriety. The success of the operation must in a great measure be ascribed to the inflammatory changes induced by the operation, and perhaps to the anterior lip of the uterus becoming hypertrophied, which is no doubt due to the effusion of plastic matter.

The tumour was examined under the microscope, and no cancer-cells detected; and, as the history of the disease is not